AMENDMENTS TO THE SPECIFICATION

Please amend the paragraph beginning on page 4, line 11 as follows:

In accordance with the present invention a method and apparatus provides for the repricing of reimbursement claims against contracts. In an embodiment of the present invention, a method for repricing a reimbursement claim under at least one contract includes converting each contract into a series of contractual terms and converting the claim into a series of claim lines. The method ~~than~~ then sequentially compares each claim line against each contractual term of a contract. When a claim line satisfies a contractual term, the method identifies the contractual term as a matching contractual term associated to the claim line. Upon identifying all matching contractual terms, the method will determine any priority conditions associated to the matching contractual terms, and eliminate any matching contractual terms that are excluded by such priority conditions. The method then calculates the reimbursement amount for the claim by determining the reimbursement charges for the non-excluded matching contractual terms. The method may then determine and make any adjustments depending upon any discounts or stop losses for the entire reimbursement amount.

Please amend the paragraph beginning on page 10, line 13 as follows:

When selecting the Ratesheets tab 12d, shown in Figure 1, a rate sheet window 30 opens, illustrated in Figure 3. The rate sheet window 30 permits the user to create and manage the rate sheets. The bottom of the window contains a series of tools that provide the user with the ability to create and manage rate sheets and terms. The tools used for maintaining and creating rate sheets are Add Sheet 32a, Change Sheet 32b, Delete Sheet 32c and ~~Cop Sheet 32d. While~~ Copy Sheet 32d, while additional tools are used for maintaining and creating the terms of each rate sheet, such as Add Item 32e (or add term), Change Item 32f, Delete Item 32g and Copy Item 32h.

Please amend the paragraph beginning on page 11, line 1 as follows:

The Code Groups tab 12f, provides the user with the ability to maintain groupings of qualifying pre-defined codes. When entering in a rate sheet, each contract term is defined under a sub-section headings, for instance, Medical and ICU/CCU/NICU. Code grouping

permits the user to define which codes qualify for repricing under these sub-sections. For example, when using revenue codes, the industry has determined that revenue codes 120-123 define procedures under a Medical sub-section, while the revenue codes ~~174,~~ 174 and 200-219 define procedures under the ICU/CCU/NICU sub-section. The pre-defined codes include age, ICD9 procedure and diagnosis codes, DRG codes, CPT-4 codes, revenue codes, and Provider groups (such as Surgeon, Assistant Surgeon, and Anesthesiologist). Under the code groups tab 12f the pre-defined code groups may be adjusted or new groups may be created to cover specific terms in a rate sheet.

Please amend the paragraph beginning on page 11, line 30 as follows:

Illustrated in Figures 6a, 6b and 6c, when a new claim is to be created a new claim form window 60 is opened. Using the input devices mentioned above, a user enters in a ~~claim,~~ claim to be repriced. Figure 7 illustrates a claim 70 that has been created and saved in the system and is awaiting to be repriced. As illustrated the claim contains several claim lines, rows 72a, 726, 72c, 72d. Listed in each row are specific revenue codes, column 74a, general descriptions of the codes, column 74b, the number of units of each code, column 74c, and the total charges, column 74d, and etc.

Please amend the paragraph beginning on page 13, line 21 as follows:

In this example, a simple Provider Contract 140, as shown in Figure 9, is converted to a "Completed Rate Sheet" 200, shown as split screens in Figures 19a and 19b. As shown in Figure 9 the Provider Contract ~~150~~ 140 between a Medical Center and an Insurer for medical reimbursement claims contains various terms. As provided, the Provider Contract ~~150~~ 140 defines the following terms: Medical per diem cost at $750.00; Surgical per diem cost at $950.00; Normal Delivery at $1,400.00 for 1-2 day stay case rate with an additional $450.00 charge for each additional day; Cesarean Section at $2,800.00 for 1-2 day stay case rate and $500.00 for each additional day; all other covered Inpatient Services and all Outpatient Services will be discounted at 15% from billed charges; and a Stop Loss for any case in which charges exceed $20,000 the Medical Center will be paid 85% of the total billed charges.

Please amend the paragraph beginning on page 16, line 1 as follows:

The qualification window 174 permits the user to select the type of codes associated to the term and the value of the codes. As mentioned above, the pre-defined codes types, selected from code type pull down menu 174c includes, for example, ICD9 procedure and diagnosis codes, DRG codes, CPT-4 codes, revenue codes, etc. When using a specific range of codes, the code value box 174a is selected. The user then enters in a range of code values in the value range boxes 175a and 175b, illustrated in Figure 12a. When, however, the code grouping box 174b is selected, the user selects the code group from a pre-defined group of codes from a drop-down menu 177, illustrated in Figure 12b.

Please amend the paragraph beginning on page 17, line 1 as follows:

Illustrated in Figure 13a and in accordance with the Provider contract 140 the first term, "Medical Per Diem repriced at $750.00 a day," has ~~be~~ been entered. As illustrated, the description window 182 contains information in relation to the term. The description box 182a contains the term "Medical" and within the date boxes 182b and 182c are effective dates. The qualifications window 184 indicates that this term uses code grouping by selecting the code grouping box 184a. The type of codes selected in the code type box 184c is revenue codes with the pre-defined code group being "'Per Diem - Medical," defined in the code group pull down menu 184b. The calculation window 186 indicates that the calculation assigned to this term is a single level per diem calculation. Upon selecting a calculation from the calculation window 186 the system generates and displays each calculation as an English language paragraph in the lower window 188 with a series of calculation boxes 188a interspersed in the paragraph. The user enters in a price of "$750.00" in the per diem calculation box 188a. Lastly, the user defines the priority of this term in comparison to other terms defined under the Per Diem section. This is accomplished by selecting a pair of priority notes, or footnotes, from the footnote pull down windows 189a and 189b, discussed in further detail below.

Please amend the paragraph beginning on page 17, line 23 as follows:

Referring now to Figure 13b, the second term "Surgical at $950.00 a day" from the Provider contract 140 is entered in rate sheet term window 190. As in the Medical term Figure 13a, the Surgical tern uses revenue codes, in code type box 192a and the pre-defined code group "Per-Diem Surgical" defined in the code group pull down menu 192b. In this instance the revenue codes overlap, the pre-defined revenue codes for both Per-Diem Medical

and Surgical terms include the codes 110-113 and 120-123. During the repricing process, claims with a revenue code of 111 for example, will qualify for both the Medical and Surgical terms. Since the Surgical term is listed last in the Per-Diem section all claims with overlapping revenue codes reprice at the Surgical rate of "$950.00", defined in calculation box 192c. One way to differentiate a surgical service from medical care is by the presence of an ICD9 procedure code on the claim. To build the Surgical term with both the revenue code and an ICD9 procedure code is to add a subrate sheet 198 marked in a subrate sheets box 194. The subrate sheet allows for the creation of more than one qualifier, e.g. a revenue code qualifier and an ICD9 procedure code qualifier. During the repricing process, all claims with an overlapping revenue code and no ICD9 procedure code reprice with the Medical term, while all claims with an overlapping revenue code and an ICD9 procedure code reprice with the Surgical term. As illustrate in Figure 13c, the rate sheet window 195 now contains the two subsections, Medical and Surgical under the section Per Diem. The system, using the beans entered from the rate sheet term window, generates and displays each term as a paragraph.

Please amend the paragraph beginning on page 22, line 12 as follows:

Starting with step 250, the method may begin by ~~exeluded~~ excluding any claim codes from the claim that are substantially equal to any codes listed in the exclusion sections of the rate sheet, step 252. These codes are temporarily excluded from the repricing of the entire claim, and are added back to the claim after the claim has been repriced, step 286. Following step 252, the method then continues to determine the nature of the service, for instance the amount of days and/or the quality of care, step 254. This provides the method with the ability to process the claim under the correct amount of days. Next in step 256, the method analyzes the claim under the Case Rate section. The method sequentially compares the claim codes and determines if ~~the~~ any of the claim codes substantially equal any of the codes defined in the contractual terms listed in the case rate section. If a claim ~~eodes~~ code falls under the case rate section of the rate sheet the method determines the type of service, whether the claim ~~eodes~~ code qualifies as an outpatient or inpatient, step 258. The method then determines which term(s) apply, step 260, by determining the priority of the terms. Since terms defined under the case rates section are applied to the entire claim, the method, based upon the qualifying term(s), will reprice the entire claim, step 262.

Please amend the paragraph beginning on page 23, line 26 as follows:

Referring now to Figure 23, the repricing engine using this processing flow may begin to reprice claims, for instance repricing the completed claim 70 illustrated in Figure 7 repriced against the Rate Sheet 200 illustrated in Figure 20. As shown in Figure 7, the completed claim 70 includes four claim lines, 72a, 72b, 72c and 72d. Each claim line has a claim code listed in column 74a. ~~As such claim~~ Claim line 72a for Room and Board includes 'claim code 120' and is priced at $4,000 for 4 units (or four days). Claim line 72b includes 'claim code 350', which represents coronary care, and is priced at $6,000. Claim line 72c has 'claim code 250', which represents Pharmacy and is priced at $10,000. Finally, claim line 72d has 'claim code 001' which represents total charges of $20,000.

Please amend the paragraph beginning on page 24, line 5 as follows:

When the claim is repriced, the repricing engine, following the processing flow of Figure 22, can logically reprice the completed claim 70. Since there are no exclusions in the Rate Sheet 200 Figure 20), the method may move to determine the amount of days, step 254. By calculating the units charged in the Room and Board claim line 72a, the method can determine that the amount of days is four. The method then moves to determine which sections in the Rate Sheet 200 apply. Reviewing the Case Rate section, step 256, the method logically determines that the codes listed in the completed claim 70 may not be categorized under neither the Normal Delivery Case Rate or the C-Section Case Rate, Figure 20. As such the method continues, step 264, to determine whether any claim codes qualify under the Per Diem Section. The first claim line 72a, includes a revenue claim code of 120, which falls under the code grouping defined under the Medical tern. The method then must determine the type of service provided, inpatient or outpatient, step 266. Since the completed claim 70 included a bill code of '111' in box 71, the method ~~determine~~ determines that this claim is for inpatient services. If the box 71 included the bill code '112' the method would have determined that the claim was for outpatient services.

Please amend the paragraph beginning on page 26, line 1 as follows:

Under this processing ~~flow,~~ flow of Figures 22 and 23, the other claim lines would be bundled together under the Medical Per Diem section, such that the prior total of $20,000 would be subjected to repricing to the new amount of $3,000. As seen in Figure 24, the nature of the repricing can be graphically displayed in Repricing window 300, which describes that the claim code (revenue code) of 120 represents a Medical Per Diem charge with four units (days), as such the original charge of $20,000 was discounted $17,000 to a repricing of $3,000.

Please amend the paragraph beginning on page 26, line 8 as follows:

Even if the claim was unbundled into four separate claims, one claim for each claim line, the repricing engine will identify the four separate claims as originating from the same provided service. By searching the patient, days of care provided, the nature of the care, and the services preformed the repricing engine will identify the four unbundled claims as a single claim, and reprice the group of claims as a single claim. In the alternative, under various reasons, a claim once entered may need to be unbundled into separate ~~claims, as such~~ claims. As such, the repricing engine, can unbundle the claim into separate claims, separate the claim codes accordingly and reprice the unbundled claims.

Please amend the paragraph beginning on page 26, line 24 as follows:

The contracts platform permits virtually all contracts to be interactive, meaning that the information is shared and used between the contracts and between the other platforms and engines. This allows the platforms to be changed, customized or new platforms may be added without damaging the integrity of the shared or stored information. As ~~such~~ such, as the industry or Insurer defines or re-defines the calculation categories or sections, the platforms may be changed or altered accordingly without damaging or effecting the information.

Please amend the paragraph beginning on page 27, line 1 as follows:

As mentioned above, the platforms may be designed to accept Claims over various communication mediums. If utilized by third party administrators or by ~~employers~~ employers, the ability to maintain a database to accept and reprice claims may be difficult,

time consuming and expensive. As ~~such~~ such, the need exists to provide a single data center maintaining and managing numerous networks. Referring to Figure 27, a single data center ~~330,~~ 330 is shown with a plurality of networks stored thereon, network A 332 corresponding to Insurer A; network B 332b corresponding to employer B; network C network 332c corresponding to PPO C;...; network N 332n corresponding to Insurer n. Each network contains a plurality of rate sheets privy to the owner of the network, such as a PPO, Insurer, employer, or third party administrator. Various providers would submit reimbursement claims to the data center 330 over various wireline 334 and wireless 335 communication mediums. The data center would determine which network the claim is associated to and then reprice the claim and graphically display, transmit or electronically send to the submitter a reimbursement worksheet, such as the graphically displayed reimbursement window 300, Figure 24.

Please amend the paragraph beginning on page 27, line 17 as follows:

The data center is also accessible by the network's administrators, through various wireline 338 or wireless 339 communication mediums. The network's administrators would access their ~~networks,~~ networks and receive the submitted reimbursement claims along with corresponding reimbursement ~~worksheet,~~ worksheet so that payments to the submitter may be made. Other outside networks 342, such as Network XX, may be maintained and managed outside of the data center by the outside network's administrators. However, through various links the data center may be provided with access to the outside network 342. This would permit a provider 334 to submit a claim, to be reimbursed against the outside network 342. The data center receiving the claim would access the outside network 342 and reprice the claim against the rate sheets contained thereon. In this instance any proprietary information in relation to the rate sheets is maintained by the administrator of Network XX.

Please amend the paragraph beginning on page 27, line 29 as follows:

Moreover, the data center may be accessible to patients ~~340,~~ 340 through various mediums. Patients with submitted claims may be able to track the repayment or the repricing of claims submitted on their behalf. The data center may further be capable of maintaining cost histories of providers and PPOs. Insurers attempting to maintain, negotiate and create new networks of PPOs may be able to access these histories to determine possible risk allocation levels and to locate specific PPOs that meet their qualifications.